TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ronald D. Linderman, D.C.

Respondent Name
FedEx Ground Package System, Inc.

MFDR Tracking Number
M4-17-1050-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The code billed was 99456 and is justified below … Determination of MMI Examination … 1st Examination $350 … Impairment Ratings for Body Parts: … Lower Extremities $300"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2016	Designated Doctor Examination	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The submitted documentation does not include explanations of benefits.

Issues

1. Did FedEx Ground Package System, Inc. (FedEx) respond to the medical fee dispute?
2. Does a dispute exist for the services in question?

Findings

1. The Austin carrier representative for FedEx is Flahive, Ogden & Latson. Flahive, Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on December 20, 2016.

   28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received on behalf of FedEx from Flahive, Ogden & Latson to date. The division concludes that FedEx failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Ronald D. Linderman, D.C. is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on March 1, 2016. 28 Texas Administrative Code §133.307(c)(2)(K) requires a request from a health care provider for medical fee dispute resolution to include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

   Review of the documentation submitted to the division does not find evidence of EOBs or of carrier receipt of a request for an EOB. Further, the documentation does not support that billing for the services in question were submitted to the insurance carrier prior to the request for medical fee dispute resolution. The division concludes that a dispute does not exist for the services in question. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	April 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.